CHAPTER III - FINANCIAL ELIGIBILITY

3.01 Medicaid Eligibility

Financial eligibility for the Medicaid Home and Community-Based Services Waivers covered by this Manual is based on Section 1915 (c) of the Social Security Act, Wisconsin Statutes and administrative code and the Medicaid State Plan. Program implementation processes for BDDS-covered Waivers are outlined in the Medicaid Handbook, the Income Maintenance Manual, and this Manual.

Because of higher income criteria under these Waivers, many people residing in the community who would otherwise be ineligible for Medicaid may become eligible via the community Waiver programs. Spousal impoverishment protections available to spouses of institutionalized persons also apply to Waiver participants (See Section 3.07 (B), below). Children are considered for financial eligibility without regard to the family's income and assets. The parental fee, when implemented, is separate from financial eligibility and cost-share.

Financial eligibility for community Waiver program participation is broken down into three eligibility groups: Group A, Group B, or Group C. The county is responsible to document the individual's Medicaid eligibility on an annual basis except when the participant is considered Grandfathered (state-only SSI recipient); that review must occur quarterly. A person who is not eligible for Medicaid is not eligible for Medicaid Waiver services. Changes in a participant's financial status may impact financial eligibility, cost-share, and/or spend-down amounts, and should be processed as soon as they are reported. When a change in cost-share or spend-down occurs, the county must send the participant a written notice, including appeal rights.

There are prescribed forms and documents used in the referral and eligibility determination process. These include:

1. Medicaid Waiver Eligibility and Cost Sharing Worksheet: (DDES-919, see Appendix A)

2. Declaration Regarding Transfer of Resources: (DDES 919-D)

3. Spousal Impoverishment Income Allocation Worksheet

4. Client Assistance for Re-employment and Economic Support (CARES) Referral Form

5. CARES Medical Status Codes

A. Group A

Group A includes applicants who are Medicaid-eligible via SSI, SSI-E and 1619. Children participating in the Katie Beckett Program, applicants participating in a full benefit Medicaid sub-program and persons who have met their deductible are also members of Group A. Group A participants have no cost-share.

For children's financial eligibility when Katie Beckett eligibility has already been established, see Section 3.02 below. Each year, or whenever the participant's financial situation changes, Sections I, II and V of the Medicaid Waiver Eligibility and Cost-Sharing Worksheet (DDES 919) are completed for each Group A Waiver participant. Children who were previously eligible under the Katie Beckett Program must continue to have countable income and assets equal to or less than 300% of the current SSI Federal Benefit Rate (this rate changes each year).

B. Group B

Group B includes applicants who do not meet Group A criteria and whose countable income is equal to or less than 300% of the current SSI Federal Benefit Rate (this rate changes each year). Group B also includes persons eligible through Medicaid partial benefit programs such as Presumptively Eligible Pregnant Women, Emergency Services for Non-qualifying Aliens, Tuberculosis-related Medicaid, partial benefit Medicaid beneficiaries including Qualified Medicare Beneficiaries only (QMBs), Specified Low Income Medicare Beneficiaries only (SLMBs), SLMB + or Qualified Disabled and Working Individuals (QDWI).

The economic support worker determines the Group B applicant's cost-share obligation by acknowledging an applicant's health insurance and medical/remedial expense. (See Section III of DDES-919 or Appendix 25 of the Medicaid Handbook). Medical/remedial expenses are defined as those costs that directly relate to the person's care needs and/or are costs incurred while treating, preventing, or minimizing the adverse effects of illness, injury or other impairments to an individual's physical or mental health. Medical/remedial expenses are tracked on a monthly basis for the participant's Medicaid cost-share to remain accurate. In the case of Group B participants, the ESS may only count expenses which are incurred and paid by the applicant. This differs from Group C participants. The cost-share amount must be applied to Waiver covered service and must also be listed on the Individualized Service Plan. Every three months, the county must insure that the participant has paid his/her cost-share. Each time a change in medical/remedial expenses or other financial information occurs, a new CARES screen is necessary to generate a new cost-share amount. (Refer to Appendix H)

C. Group C

Group C includes applicants who are not Special Group A nor Group B-eligible, and those applicants whose countable income exceeds 300% of the current SSI Federal Benefit Rate

(amount changes annually). Group C eligibility is met if the applicant's net income, after allowable deductions, is equal to or less than the Medicaid Medically Needy income standard

(amount changes annually). The economic support worker completes the appropriate CARES screen to determine eligibility, spend-down, cost-share and spousal income allocation amounts. (See Section IV of the DDES-919 or Appendix 25 of the Medicaid Handbook). The spend-down is the amount of expense that a non-married Group C applicant must incur and spend on a monthly basis. Non-married Group C applicants must incur and spend sufficient countable expenses to meet their monthly spend-down amount. Married Group C applicants may also have a cost-share liability when income allocation and other deductions are not sufficient to offset their available income. In cases where spousal impoverishment rules apply, the process of income allocation always occurs after the applicant is found eligible.

Group C applicants must first be found medically needy to be considered eligible for the Waiver programs. They must also have sufficient long-term care-related services or expenses to "spend down" to their medically needy income limit. Expenses considered countable are those that would be the responsibility of the applicant if they were not participating in the Medicaid Waivers. The Care Manager/Support and Service Coordinator submits the CARES screen prints with the completed service packet to the appropriate Medicaid Waiver quality assurance contact for review. The Waiver start date will be reported to the ESS via the approval letter.

3.02 Children Applying For A Waiver

When the child applies for a Waiver and is Medicaid-eligible through SSI, Katie Beckett program or through 1619, he or she is considered Group A eligible. Sections I, II and V of the DDES 919 are completed. The Economic Support Unit only becomes involved when the child who applies for the Waiver is not already Medicaid-eligible or in cases where divestment of the child's assets is alleged. Please note that while there is no cost-share for children using the Waiver the state has chosen to implement a parental fee system which will become effective during the spring of 2004. Although the Department had authority to begin the parental fee system as of January 1, 2004, the fee system, when implemented, will not be imposed retroactively.

Children who began Medicaid-eligibility under the Katie Beckett Program who are transferring to the Waiver are included in Group A. Upon transfer to the Medicaid Waiver, the Support and Service Coordinator will complete the Medicaid Waiver Eligibility and Cost-Sharing Worksheet (DDES 919). A referral to the Economic Support Specialist is only necessary if divestment has occurred. The DDES-919 form includes the following two questions the answers to which the Support and Service Coordinator must determine:

1. Have the parents sold, traded, transferred or given away property, land, stocks, bonds, cash, vehicles, or anything of value in the past 36 months?

2. Have the parents created a trust or added funds to a trust within the last five years?

If the parents have made any of the transactions noted in the two questions, the Support and Service Coordinator must complete the DDES-919-D and refer the applicant to Economic

Support Specialist for investigation and financial eligibility determination. After the Economic Support Specialist makes the financial eligibility determination the Support and Service Coordinator will inform the participant of the results under Section V of the DDES-919 form.

Each year, or whenever a participant's financial situation changes, Sections I, II and V of the Medicaid Waiver Eligibility and Cost-Sharing Worksheet (DDES 919) are completed for each Group A Waiver participant. Children who were previously eligible under the Katie Beckett Program must continue to have countable income and assets equal to or less than 300% of the current SSI Federal Benefit Rate (this rate changes each year).

When the CLTS Waiver participant reaches age 18, he/she is no longer reviewed under the Category A status and will need to be considered under the financial eligibility criteria outlined below.

3.03 New Applicants Leaving a Nursing Home

New applicants being discharged from a Nursing Home who are not already receiving Medicaid are referred to the Economic Support Unit to determine eligibility or cost-share and spend-down obligation. As applicable, the economic support worker reviews the medical/remedial expense information as described under the Group B or Group C headings above. The Economic Support Unit may assign a "pending" Medicaid eligibility status. In these cases the Medicaid eligibility is only available once the applicant moves to a Waiver-allowable setting. If the individual is potentially SSI eligible, the applicant should be referred to the local Social Security office.

3.04 Cost-Sharing

A. Payment and Documentation

No cost-share requirement can be applied to participants eligible through Group A. Cost sharing only affects participants who are Group B or C-eligible. When a cost-share has been determined, the person's eligibility for Waiver services can only be maintained if the cost-share liability is met. It is imperative that the county maintain a fiscal record and system that is able to track and document that the participant has paid the appropriate cost-share, and that it is applied toward Waiver services.

A participant is not required to pay any cost-share if there are no Waiver services provided in a given month. The participant is also not required to pay any amount of his or her cost-share that is in excess of the cost of his/her Waiver services in a given month. When a participant is institutionalized for a full calendar month, collection of the participant's cost-share obligation for that month is not permitted.

Generally, only applicants in Group B are assigned a cost-share. It is possible for a married participant who is Group C-eligible to also have a cost-share after allocations under spousal

impoverishment regulations occur. Questions surrounding rules relating to cost-share and spend-down rules should be referred to the county's Economic Support Unit.

B. Multiple Program Cost-Shares

For participants receiving services from both the Medicaid Waiver and another long-term support program where a separate cost-share might be determined, the participant is only liable for the Waiver cost-share payment.

C. Cost-Share and Room and Board

In cases where a cost-share applies, the maximum Personal Maintenance Amount (PMA) cannot exceed 300% of the SSI Federal Benefit Rate (this amount changes annually). The PMA is a calculation of CARES and is a combination of the Basic Needs Allowance, the Earned Income Disregard and the Special Housing Amount. The Special Housing Amount calculation is available to applicants whose monthly housing expenses (rent, mortgage, utilities, property taxes) are in excess of $350 (refer to the Medicaid Handbook, a specific guide to the PMA calculation). ESS uses the applicant's PMA calculation in the individual's cost-share calculation.

3.05 Voluntary Contributions; Medicaid Supplementation and the Waiver Programs

The participant, a family member, guardian, or another person may elect to make a voluntary contribution toward the cost of services not covered by the Waiver. The County agency administering these Waiver programs may not compel an applicant, participant or other interested person to contribute funds toward the cost of planned services covered by the Waiver beyond the amount of the participant cost-share, spend-down required to meet financial eligibility or parental fee system.

A voluntary contribution toward the cost of services not covered by the Waiver may be accepted if there is clear documentation that the person making the contribution understands that the payment is not required as a condition of the applicant/participant's initial or continued eligibility for Waiver program services.

The following general requirements are provided by the Department's Office of Legal Counsel and are based on state and federal statutes and rules. These summarize all Medicaid-related requirements that apply to all Waiver programs. Counties are encouraged to directly refer to the actual laws and rules covering this subject and to consult with their Corporation Counsel if they choose to make any use of voluntary contributions to cover Waiver services:

1. No payment may be required as a condition of an applicant being admitted into a Waiver program.

2. No payment may be required as a condition of a Waiver participant remaining in a Waiver program.

3. No payment may be required or accepted in connection with provision of any Medicaid State Plan-covered service.

4. No payment may be required or accepted in connection with provision of any Waiver service that is listed in the client's care plan.

5. No payment may be required or accepted in connection with provision of any Waiver service that is medically-necessary, in the sense that the Waiver participant would need to live in an institution but for provision of service.

6. No payment may be required in connection with provision of any service that is allowable under the Waiver.

7. No payment may be accepted in connection with provision of any service that is covered and allowable under the Waiver unless:
   a. There is documentation that the person making the payment understands that the payment is not required as a condition of the client's admission to or remaining in the Waiver program.
   b. The service is not listed in the participant's individualized service plan.
   c. The service is not medically necessary, in the sense that the participant would not need to live in an institution if the service were not provided.

8. A payment may be accepted in connection with provision of any service that is neither a Medicaid State Plan service nor allowable under the Waiver.

9. A "voluntary contribution" (i.e., a payment meant as a recognition of or expression of gratitude for services to a client) may be accepted if there is documentation that the person making the contribution understands:
   a. That the payment is not required as a condition of the client's admission to or remaining in the Waiver program.
   b. That the payment is neither required nor accepted in exchange for or otherwise in connection with provision of any service or services.

3.06 Divestment

State and federal law contain detailed regulations pertaining to assets, income and treatment of these resources in Medicaid applications. Divestment is the disposal or transfer of income and/or any countable asset by the applicant/participant and/or by his/her spouse, for less than fair market value. Federal regulations and state law preclude eligibility for certain long-term care Medicaid programs when divestment has occurred and the divestment has not been "cured" (corrected). Divestment provisions apply to all eligibility groups (Groups A, B and C) of CIP 1A, CIP 1B, BI and CLTS Waivers (refer to the Medicaid Handbook for detailed information).

3.07 Spousal Impoverishment

A. Asset Allocation

The purpose of asset allocation is to prevent impoverishment of the spouse who is not applying for the Waiver and who is known as the "community spouse". The assets assessment is based on the total countable assets of the couple on the date of the first request for Medicaid Waiver services. The Economic Support Staff has access to the most current criteria. In certain instances, the community spouse asset share may be a court-ordered amount. In such situations the community spouse's income-generating asset share may be increased through the finding of an Administrative Hearing. The Administrative Hearing option is generally applied when the Waiver spouse's income is insufficient to raise the community spouse's income to the allowable level under spousal income allocation.

An applicant may request to have his/her assets assessed prior to making a formal application for Medicaid. When this request is made, the applicant is referred to the county Economic Support Unit for a resource assessment.

B. Income Allocation

The following chart illustrates when spousal impoverishment protections apply:

Applicant/Participant	**Applicant's or Participant's Spouse**	**Do Spousal Impoverishment Rules apply to the Applicant/Participant's Eligibility Determination and Cost-share Calculation?**
Residing in a nursing home or medical institution for 30 or more days	In community	YES
Residing in a nursing home or medical institution for 30 or more days	Residing in a nursing home or medical institution for 30 or more days	NO
Residing in a nursing home or medical institution for 30 or more days	Participating in a Medicaid Waiver	YES
Participating in a Medicaid Waiver program	In community	YES
Participating in a Medicaid Home and Community-based Waivers program	Residing in a nursing home or medical institution for 30 or more days	NO
Participating in a Medicaid Home and Community-based Waivers program	Participating in a Medicaid Home and Community-based Waivers program	YES

C. Spousal Income Allocation

Waiver participants may allocate part of their income to their spouse who resides in the community after Medicaid-eligibility has been determined (see chart above to determine if spousal impoverishment rules are applicable). The spouse who resides in the community may choose to receive part or all of this allocation depending on individual circumstances. If SSI and/or Medicaid eligibility would be jeopardized, the spouse residing in the community may choose to forego the allocation. ESS uses CARES to determine income allocations. The income allocation limits change each year (see Medicaid Handbook for updates). The spouse served by the Waiver must actually make the income available to the spouse who resides in the community in order for the allocation to be considered.

When both spouses are Waiver participants, each spouse may allocate income to the other. The allocation occurs from one spouse to the other, after determining which spouse's cost-share will be reduced by the allocation (see Medicaid Handbook for updates).

D. Family Maintenance Allowance

A Family Maintenance Allowance (FMA) for an eligible family member may be deducted from a married Waiver applicant's income in the post-eligibility phase of cost of care calculation. The FMA may be applied in households where the Waiver participant is the custodial parent of minor children living in the home and there is no spouse in the home. The FMA may also be applied in households where there are no minor children living in the home and there is a spouse in the household but spousal impoverishment policies do not apply. This allowance is not an allocation and the Economic Support Staff should not add the FMA to the other spouse's income. The staff must use the CARES or the DDES-919 to compute the Family Maintenance Allowance (refer to Appendix 25 of the Medicaid Handbook).

E. Spousal Impoverishment and Group C

When spousal impoverishment protections are applied in Group C Waiver applications, determinations are made in CARES in the following order:

1. Basic Medicaid Waiver eligibility, as determined by CARES;

2. The amount of the monthly spend-down required to establish and maintain eligibility. When income allocation options apply, the monthly spend-down must continue to be incurred (but need not be paid out);

3. The amount of spousal and family member allocations (see Appendix B); and

4. The amount of the participant's adjusted cost-share (see 3.04 above).